XII. CONTRACTS

XII

A. The reimbursement limitation for the noncontract service costs of contracting hospitals which had a valid contract during the entire settlement fiscal period shall be determined by the following method:

Noncontract Reduction = NMCN - TCL

Where:

NMCN = Noncontract Medi-Cal net cost of covered services including third-party liability amounts

TCL = PYNCPD * PDL * SYND
PYNCPD = PYNC/PYND

TCL = Total cost limit exclusive of any reductions for third-party liability

PYNCPD = Prior fiscal period noncontract cost per day

PYNC = Prior fiscal period noncontract costs

PYND = Prior fiscal period noncontract days

PDL = Per diem limit increase which shall be the target as specified in federal regulation CFR 42, Section 413.40(c)(3).

SYND = Settlement fiscal period noncontract days

1) All AA and appeal issues must pertain to the reason for the increase in the average noncontract costs per day from the prior fiscal period to the settlement fiscal period.

2) Contracting hospitals with noncontract service costs will also have an ARPDL calculation performed each FPE. The calculation will be used to determine the base period for the next FPE in the event the provider discontinues the contracting program.

B. The noncontract reimbursement reduction, if any, for partial FPE contracting hospitals those hospitals which have gone on or off contracting during their settlement fiscal period, shall be determined as follows:

Noncontract Reduction = PRNC * FYR

Where:

PRNC = NMCN/TMCN

PRNC = Proportion of reimbursement not under contract

FYR = Full fiscal period all services reimbursement reduction as determined by the PIRL.

NMCN = Noncontracting Medi-Cal net cost of covered services

TMCN = Total Medi-Cal net cost of covered services for the entire fiscal period for all services.

XIII. DISPROPORTIONATE SHARE

A. Disproportionate share payments shall be paid in accordance with the provisions of the existing State Plan (pages 18 to 37).

XIV. REIMBURSEMENT LIMITS FOR OUT-OF-STATE HOSPITALS

See Attachment 4.19-A, page 16. Provisions for Out-of-State reimbursement will remain in place on page 16.

XV. REIMBURSEMENT FOR SHORT-DOYLE/MEDI-CAL ACUTE INPATIENT SERVICES

Reimbursement for Short-Doyle/Medi-Cal (SD/MC) acute inpatient hospital mental health services is either on a retrospective or prospective basis, based on determinations by the Department of Mental Health of individual county operations, and the preference of individual providers. Reimbursement shall be based on the lesser of:

1) Each provider's customary charges.

2) Depending on which reimbursement method the provider is under, each provider's allowable cost or negotiated rate (NR) or negotiated net amount (NNA), both of which are expressed by the established service function and unit of service (i.e., patient day) for providers contracting on an NR or NNA basis pursuant to Section 5705.2 of the

Welfare and Institutions Code.

3) A per diem rate established annually by the Department based on 125 percent of the statewide average of the costs of services as reflected in the most recent provider's cost reports. This rate shall be adjusted annually to reflect any cost of living allowance provided for in the Budget Act.

If application of this per diem rate would result in a substantial inability to provide SD/MC mental health services, the computed rate may be waived by the Department of Mental Health pursuant to Section 5705.1 of the Welfare and Institutions Code, subject to approval by the Department.

INCREASE IN MEDICAID PAYMENT AMOUNTS FOR
CALIFORNIA DISPROPORTIONATE PROVIDERS

A. Disproportionate Share Hospitals

1. All hospitals in the State reimbursed under the State Plan provisions or the Selective Provider Contracting Program which meet the disproportionate share provider criteria specified in subsection 2 shall receive additional payment amounts (i.e., payment adjustments). The additional payment amounts shall be determined using the method described in Section C below, as modified by other provisions of this Attachment. The disproportionate share payment amounts shall be distributed concurrent with certain claims that are processed on and after July 1, 1991, as described in this attachment. For the 1994-95 and 1995-96 payment adjustment years, the payments shall be made for three quarters of the state fiscal year by adjusting the payment adjustment amounts in accordance with Sections H. and I. of this Attachment. In addition, the Department shall pay to eligible hospitals any supplemental lump-sum payment adjustment amounts and any secondary supplemental payment adjustments that are payable and shall adjust payment amounts, in accordance with applicable provisions of this Attachment.

2. Hospitals shall be deemed disproportionate share hospitals if for a calendar year ending 18 months prior to the beginning of a particular State fiscal year:

   a. The hospital's Medicaid inpatient utilization rate as defined in Section 1396 r-4 (b)(2) of Title 42 of the United States Code, is at least one standard deviation above the mean Medicaid inpatient utilization rate for hospitals receiving Medicaid payments in the State, or

   b. The hospital's low income inpatient utilization rate as defined in Section 1396 r-4 (b)(3) of Title 42 of the United States Code, exceeds 25 percent;

   and in each case,

   c. The hospital has at least two obstetricians with staff privileges at the hospital who have agreed

to provide obstetric services to individuals entitled to such services under the State Medicaid Plan. In the case of a hospital located in a rural area (that is, an area outside of a Metropolitan Statistical Area, as defined by the U.S. Executive Office of Management and Budget), the term "obstetrician" includes any physician with staff privileges at the hospital to perform nonemergency obstetric procedures. This requirement does not apply to a hospital (1) the inpatients of which are predominantly individuals under 18 years of age; or (2) which does not offer nonemergency obstetric procedures as of December 22, 1987; and

d. For the 1994-95 payment adjustment year and subsequent payment adjustment years, the hospital's Medicaid inpatient utilization rate, as computed under paragraph a. above, is at least one percent.

B. Definitions

The following definitions apply for purposes of this Attachment:

1. "Department" means the State Department of Health Services.

2. "Disproportionate share list" means an annual list of disproportionate share hospitals that provide acute inpatient services issued by the Department for purposes of this Attachment.

3. "Fund" means the Medi-Cal Inpatient Payment Adjustment Fund.

4. "Eligible hospital" means a hospital included on a disproportionate share list, which is eligible to receive payment adjustments under this Attachment with respect to a particular state fiscal year.

5. "Hospital" means a health facility that is licensed pursuant to Chapter 2 (commencing with Section 1250) of Division 2 of the Health and Safety Code to provide acute inpatient hospital services, and includes all components of the facility.

6. "Payment adjustment" or "payment adjustment amount" means an amount paid under this Attachment for acute inpatient hospital services provided by a disproportionate share hospital.

7. "Payment adjustment year" means the particular state fiscal year with respect to which payments are to be made to eligible hospitals under this Attachment.

8. "Payment adjustment program" means the system of Medi-Cal payment adjustments for acute inpatient hospital services established by this Attachment.

9. "Annualized Medi-Cal inpatient paid days" means the total number of Medi-Cal acute inpatient hospital days, regardless of dates of service, for which payment was made by or on behalf of the Department to a hospital, under present or previous ownership, during the most recent calendar year ending prior to the beginning of a particular payment adjustment year, including all Medi-Cal acute inpatient-covered days of care for hospitals which are paid on a different basis than per diem payments.

10. "Low-income utilization rate" means a percentage rate determined by the Department in accordance with the requirements of Section 1396r-4(b) (3) of Title 42 of the United States Code, and included on a disproportionate share list.

11. "Low-income number" means a hospital's low-income utilization rate rounded down to the nearest whole number, and included on a disproportionate share list.

12. "1991 Peer Grouping Report" means the final report issued by the Department dated May 1991, entitled "Hospital Peer Grouping."

13. "Major teaching hospital" means a hospital that meets the definition of a university teaching hospital, major nonuniversity teaching hospital, or large teaching emphasis hospital as set forth on page 51 of the 1991 Peer Grouping Report.

14. "Children's hospital" means a hospital that meets the definition of a children's hospital-state defined, as set forth on page 53 of the 1991 Peer Grouping Report, or which is listed in subdivision (a), or subdivision (c) to (g), inclusive, of Section 16996, of the California Welfare and Institutions Code.

15. "Acute psychiatric hospital" means a hospital that meets the definition of an acute psychiatric hospital, a combination psychiatric/alcohol-drug rehabilitation hospital, or a psychiatric health facility, to the extent the facility is licensed to provide acute inpatient hospital service, as set forth on page 52 of the 1991 Peer Grouping Report.

16. "Alcohol-drug rehabilitation hospital" means a hospital that meets the definition of an alcohol-drug rehabilitation hospital as set forth on page 52 of the 1991 Peer Grouping Report.

17. "Emergency Services Hospital" means a hospital that is a licensed provider of basic emergency services as described in Sections 70411 to 70419, inclusive, of Title 22 of the California Code of Regulations, or that is a licensed provider of comprehensive emergency medical services as described in Sections 70451 to 70459 inclusive, of Title 22 of the California Code of Regulations.

18. "OSHPD" means the Office of Statewide Health Planning and Development.

19. "OSHPD" statewide data base file" means the OSHPD statewide data base file from all of the following:

    (A) Hospital annual disclosure reports, filed with the Office of Statewide Health Planning and Development pursuant to Section 128735 (formerly Section 443.31) of the Health and Safety Code, for hospital fiscal years which ended during the calendar year ending 13 months prior to the applicable February 1.

    (B) Annual reports of hospitals, filed with the Office of Statewide Health Planning and Development pursuant to Section 127285 (formerly Section 439.2) of the Health and Safety Code, for the calendar year ending 13 months prior to the applicable February 1.

    (C) Hospital patient discharge data reports, filed with the Office of Statewide Health Planning and Development pursuant to subdivision (g) of Section 128735 (formerly Section 443.31) of the Health and Safety Code for the calendar year ending 13 months prior to the applicable February 1.

20. "Acute inpatient hospital day", for the purposes of this Attachment, will include days in which an individual (including a newborn) is an inpatient in the hospital, whether or not the individual is in a specialized ward

and whether or not the individual remains in the hospital for lack of suitable placement elsewhere.

21. "Total per diem composite amount" means, for each eligible hospital for a particular payment adjustment year, the total of the various per diem payment adjustment amounts to be paid to the hospital for each eligible day as calculated under applicable provisions of this Attachment.

22. "Supplemental lump-sum payment adjustment" means a lump-sum amount paid under this Attachment for acute inpatient hospital services provided by a disproportionate share hospital, but does not include secondary supplemental payment adjustments as described in subsection 26.

23. "Projected total payment adjustment amount" means, for each eligible hospital for a particular payment adjustment year, the amount calculated by the Department as the projected maximum total amount the hospital is expected to receive under the payment adjustment program for the particular payment adjustment year (including all per diem payment adjustment amounts and any applicable supplemental lump-sum payment adjustments, but not including secondary supplemental payment adjustments as described in subsection 26).

24. "To align the program with the federal allotment" means to modify the size of the payment adjustment program to be as close as reasonably feasible to, but not to exceed, the estimated or actual maximum state disproportionate share hospital allotment for the particular federal fiscal year for California under Section 1396r-4(f) of Title 42 of the United States Code.

25. "Descending pro rata basis" means an allocation methodology under which a pool of funds is distributed to hospitals on a pro rata basis until one of the recipient hospitals reaches its maximum payment limit, after which all remaining amounts in the pool are distributed on a pro rata basis to the recipient hospitals that have not reached their maximum payment limits, until another hospital reaches its maximum payment limit, and which process is repeated until the entire pool of funds has been distributed among the recipient hospitals.

26. "Secondary supplemental payment adjustment" means a payment adjustment amount, whether paid or payable, to an eligible hospital as a second type of supplemental distribution earned as of June 30, 1996, with respect to the 1995-96 payment adjustment year.

27. "OBRA 1993 payment limitation" means the hospital-specific limitation on the total annual amount of payment adjustments to each eligible hospital under the payment adjustment program that can be made with federal financial participation under the provisions of Section 1396r-4(g) of Title 42 of the United States Code, as implemented pursuant to Section J. below.